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Institute for Behavioral Health

Delivery System Considerations for Integrating Addiction and Mental Health Treatment into Primary Care Settings

Sharon Reif, PhD
Senior Scientist, Institute for Behavioral Health
Heller School for Social Policy & Management, Brandeis University

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Systems-focused "adoption of innovations" framework may be key

- Integrated MH/SUD treatment in primary care is still not the norm
  - despite some examples (e.g., antidepressants, alcohol screening)
- Traditional "adoption of innovations" models inform change within individual programs or settings
- A systems focus highlights essential aspects beyond the individual program/setting*
  - **resource system** – e.g., delivery system support, funding, regulatory, management and oversight
  - **knowledge purveyors** and **change agents** – e.g., state substance use agencies, technical assistance providers, other "champions"
  - **outer context** – e.g., national efforts on opioid addiction, state policies

*Greenhalgh et al. 2004

Delivery and payment systems can facilitate change and address systemic barriers

Develop and support integrated care models	• Reduces stigma • Highlights value to system
Provide technical assistance for MH/SUD treatment & support services	• Addresses lack of knowledge/confidence • Provides referral sources
Fund or incentivize integrated care	• "Carrot" to encourage change
Pay for integrated care services e.g., consultation, care management	• Reduces siloes • Supports infrastructure
Reduce regulatory and financial barriers	• Addresses potential pitfalls for sustainability

Delivery and payment systems must be considered together

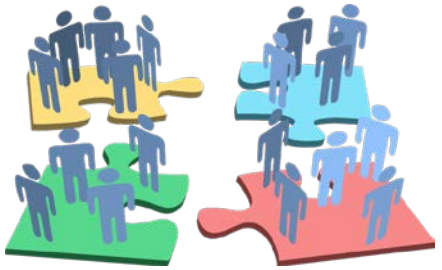
- Delivery system changes do not operate in a vacuum
- Payment systems must also be engaged to ensure
  - access to care for individuals
  - payment of providers
  - sustainability of integrated care models
- Quality may need to be assessed differently in integrated models vs. primary care or specialty MH/SUD
  - Both delivery and payment systems can emphasize quality through goals, metrics, and incentives

(NIDA P30 DA035772)

Likely facilitators of delivery systems change

- "Champions" within settings and across the system(s)
  - Raise awareness, reduce stigma, share knowledge and successes, etc.
- Flexibility in implementation
  - Many types of primary care practices, settings, MH/SUD knowledge levels, existing relationships
  - Variations can make consistent implementation at a system-level challenging
- Building on organic successes
  - Identify approaches that already work, decide how to expand and improve
- Considering sustainability early and often for effective system transformation
  - e.g., reimbursement rates, infrastructure funding

Challenges in moving integrated primary care/MH/SUD from innovation → intervention → business as usual



- Not just one system – multiple players in service delivery and payment
  - Primary care, specialty MH, specialty SUD, social services, etc.
  - Multiple payers, multiple delivery systems
- Top-down system interventions may not diffuse to individual providers
- Nominal or partial engagement – integrated care in concept but not fully in practice
- Limited resources for non-billable infrastructure support
- Overlap with other initiatives (local, state, payers, etc.) splits ability to focus
- Need to address social determinants of health for success in health and recovery